

Safety Screening Form for Magnetic Resonance (MR) Procedures

Date: _____

Name (first, middle, last): _____

Gender: Male Female Age: _____ Date of Birth: _____

Height: _____ Weight: _____

If uncertain of any answer below, please circle and leave blank to discuss with the technologist.

Why are you having this examination (medical problem)?

List current medications:

- None

List all allergies:

- None

Date of last menstrual period _____

Yes No Is there a possibility that you are pregnant?

Yes No Are you post-menopausal?

Yes No Are you breast feeding?

Please indicate if you have or have not had any of the following:

- Yes No Previous MRI examination

Facility name and city: _____

Date of examination: _____

Body part imaging: _____ Reason for examination: _____

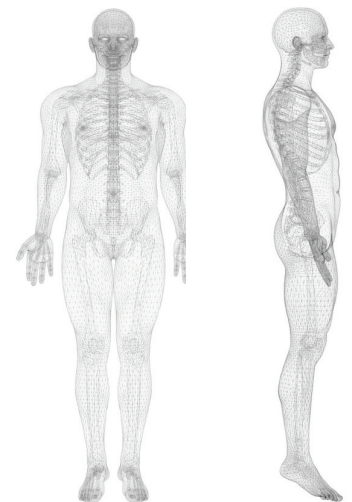
- Yes No Surgery or medical procedure of any kind

If yes, list all prior surgeries and approximate dates: _____

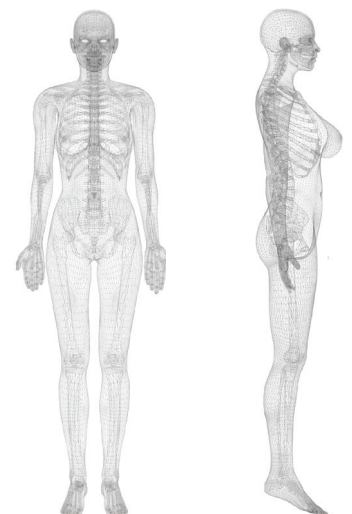
MR Hazard Checklist

Please mark the location of any implant, device or metallic foreign body inside your body or site of surgical operation.

Male:



Female:



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- Yes No Injury by a metal object or foreign body (e.g., bullet, BB, shrapnel)
If yes, explain: _____
- Yes No Injury to your eye from a metal object
 Yes No If yes, did you see medical assistance?
If yes, describe what was found: _____
- Yes No Foreign body removed from eye
If yes, describe what was taken out: _____
- Yes No Asthma or other allergic respiratory disease
- Yes No Kidney disease
- Yes No Diabetes
- Yes No Hypertension
- Yes No Previously received contrast agent (dye) for a CT, MRI or other X-ray or study
- Yes No Allergic reaction to CT, MRI, X-ray contrast agent (dye)
If yes, explain: _____
- Yes No Spinal fusion procedure
- Yes No Endoscopy or colonoscopy in last three months

The following items may be harmful to you during your MR scan and may interfere with the MR examination. You must provide a "Yes" or "No" answer for every item.

Please indicate if you CURRENTLY HAVE or HAVE EVER HAD any of the following:

Surgically implanted medical devices

- Yes No Any type of electronic, mechanical or magnetic implant
If yes, list type: _____
- Yes No Cardiac pacemaker, defibrillator or other cardiac implant (in place or removed)
- Yes No Aneurysm Clip
- Yes No Neurostimulator, diaphragmatic stimulator, deep brain stimulator, vagus nerve stimulator, bone growth stimulator, spinal cord stimulator, or any biostimulator (in-place or removed)
If yes, list type: _____
- Yes No Any type of internal electrodes or wires
- Yes No Cochlear implant
- Yes No Implanted drug pump (e.g., insulin, baclofen, chemotherapy, pain medicine)

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- Yes No Spinal fixation device
- Yes No Any type of coil, filter or stent
If yes, list type: _____
- Yes No Artificial heart valve
- Yes No Any type of ear implant
- Yes No Penile implant
- Yes No Artificial eye
- Yes No Eyelid spring and/or eyelid weight
- Yes No Any type of implant held in place by a magnet
- Yes No Any type of surgical clip or staple
- Yes No Any IV access port (e.g., Broviac, Port-a-Cath, Hickman, PICC line)
- Yes No Shunt
If yes, type: _____
- Yes No Artificial limb
If yes, what and where: _____
- Yes No Tissue Expander (e.g., breast)
- Yes No IUD
If yes, type: _____
- Yes No Surgical mesh
If yes, location: _____
- Yes No Radiation seeds
- Yes No Any implanted items (e.g., pins, rods, screws, nails, plates, wires)

Removable medical devices

- Yes No Hearing aid
- Yes No Removable drug pump (e.g., insulin, Baclofen, Neulasta)
- Yes No Any type of ear implant
- Yes No Artificial eye
- Yes No Any type of implant held in place by a magnet
- Yes No Any type of surgical clip or staple
- Yes No Medication patch (e.g., nitroglycerine, nicotine)
- Yes No Artificial limb

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If yes, what and where: _____

- Yes No Removable dentures, false teeth or partial plate
- Yes No Diaphragm, pessary

If yes, type: _____

- Yes No Have you recently ingested a "pill cam?"

If yes, date "pill cam" was ingested: _____

Personal

- Yes No Body piercings

If yes, location: _____

- Yes No Wig, hair implants
- Yes No Tattoos or tattooed liner
- Yes No Any hair accessories (e.g., bobby pins, barrettes, clips, extensions, weaves)
- Yes No Jewelry
- Yes No Metal-containing clothing material and/or underwear
- Yes No Magnetic cosmetics and hair care (e.g., magnetic eyelashes, magnetic nail polish)
- Yes No Electronic monitoring or tagging equipment (e.g., ankle monitor)
- Yes No Fitness tracker/biometer (e.g., Fitbit)

Yes No Any other type of surgically implanted medical devices, removable medical devices or personal items not covered above?

If yes, type: _____

Instructions for Patients

1. You will be provided hearing protection during your scan. You are strongly urged to use the earplugs or headphones provided to you during your MR examination, since some patients find the noise levels unacceptable, and the noise levels may affect your hearing if these provided hearing protection devices are not utilized.
2. Remove all jewelry and piercings (e.g., necklaces, pins, rings)
3. Remove all body piercings
4. Remove all hair pins, bobby pins, barrettes, clips, etc.
5. Remove all dentures, false teeth, partial dental plates
6. Remove eyeglasses and hearing aids
7. Remove watches, cell phones and pagers
8. Remove all cards with magnetic strips (e.g., credit cards, bank cards, etc.)
9. Because some clothing may contain metal even when not apparent, the MR technologist will instruct you to remove all clothing and worn/removable items from your body. MR Safe clothing will be provided to you to wear during your MRI scan. This is being done to help ensure your safety during the examination.
10. If you are unable to remove any of the above items please notify the technologist.

I have read and understand the entire content of this form.

Patient signature: _____

MD/RN/RT signature: _____

MD/RN/RT printed name: _____

Date: _____

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FOR MR Office Use Only

Patient name: _____ Patient ID # _____

Referring Physician: _____

Procedure: _____ Diagnosis: _____

Clinical History: _____

Hazard Checklist for Level 2 MR Personnel

- Yes No Pulse oximetry device
- Yes No EKG pads/leads
- Yes No Endotracheal tube
- Yes No Swan-Ganz catheter
- Yes No Extra ventricular device
- Yes No Arterial line transducer
- Yes No Foley catheter with temperature sensor and/or metal clamp
- Yes No Rectal probe
- Yes No Esophageal Probe
- Yes No Tracheotomy tube
- Yes No Guidewires
- Yes No Halo vest
- Yes No Other

If yes, explain: _____

If any Level 2 MR Personnel checklist items are answered yes, this should be brought to the attention to the covering MR Physician.

- Yes No Patient screened with ferromagnetic detector
- Yes No eGFR indicated for contrast

eGFR value: _____ Results date: _____

- Yes No If required, the patient was provided the Medication Guide

Cleared by:

MR Technologist: _____

Physician/Radiologist (if required) _____